

The Thoracic Society: a retrospect

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The phoenix-like transformation of the Thoracic Society and the British Thoracic Association into the British Thoracic Society provides an occasion for considering the circumstances that led to the existence of two societies concerned with respiratory diseases in the United Kingdom.

The history of the older society, the British Thoracic Association,¹ is a story of adaptation, by an association whose original concern had been with the problems of tuberculosis, to changes in disease prevalence and consequent changes in medical organisation. The reasons for the foundation of the Thoracic Society in 1945 can be understood only with knowledge of the position at that time of the clinical specialty constituted by those concerned with respiratory and other non-cardiac intrathoracic disease. Thoracic surgery was a relatively new and small but well-recognised specialty. Physicians specialising in pulmonary disease fell into two groups. The smaller group was composed of those on the staffs of teaching or other large general hospitals who while remaining broadly based in general medicine had taken a special interest and gained special experience in bronchopulmonary diseases, including tuberculosis. By far the larger group was composed of those working principally or entirely in the antituberculosis services. Epidemiologically, tuberculosis was the most important pulmonary disease, not only because of its frequency as a cause of prolonged illness and death in people of all ages, including the young, but also because prevention by early diagnosis and segregation of infectious patients was the most promising approach to its control; treatment was of limited efficacy. Since 1911 local authorities had been responsible for the provision of services for the diagnosis, prevention, and treatment of tuberculosis and a large number of physicians were engaged in these services, in tuberculosis dispensaries and sanatoria. The scope of these dispensaries had been widened by some local authorities in the later 1930s to include other bronchopulmonary diseases; some were sited in or near general hospitals and were starting to be called chest clinics, but physicians working in them were concerned primarily with tuberculosis and for many of them responsibility for other bronchopulmonary diseases was limited to

diagnosis. Sanatoria exclusively concerned with tuberculosis were staffed by physicians who did not usually work in dispensaries or chest clinics. Surgical procedures were frequently used in the treatment of tuberculosis and the surgery of pulmonary tuberculosis constituted a major part of the work of thoracic surgeons. To deal with this surgical facilities had been developed in some of the larger tuberculosis sanatoria and in many areas these became the major centres for thoracic surgery. The diagnosis and treatment of intrathoracic suppuration—acute and chronic empyema, lung abscess, bronchiectasis, all of which were much more frequent and less amenable to medical treatment in that preantibiotic era than they are now—and of lung cancer, which was beginning to be a major problem, were prominent in the work of these centres. In some areas the thoracic surgical centre became the principal point of reference for diagnostic and therapeutic problems in intrathoracic disease of all sorts and there was very close collaboration between physicians, radiologists, surgeons, anaesthetists, pathologists and others concerned with diseases of the chest. During the war years the formation of combined teams and centres to deal with chest wounds, both in the Armed Services and in the Emergency Medical Service, further promoted such collaboration.

The Association of Thoracic Surgeons, which had been founded in the mid-1930s, provided a forum for discussion among the surgeons working in these centres. Most physicians concerned with chest disease were members of the Tuberculosis Association, which had been founded in 1928 by the amalgamation of two older societies, the Tuberculosis Society and the Society of Superintendents of Tuberculosis Institutions. It included in its large membership some pathologists, bacteriologists, radiologists, and surgeons, united by a common interest in tuberculosis; its first president had been a laryngologist, St Clair Thomson; and at the time of the discussions which led to the foundation of the Thoracic Society its president was a thoracic surgeon, JEH Roberts. Nevertheless, the great majority of its members were physicians working primarily in the area of tuberculosis and its principal concern was with the pressing problems of tuberculosis.

In these circumstances clinicians and others collaborating in thoracic centres felt the need for a society of limited membership devoted to the advancement of knowledge in all aspects of chest disease. At a meeting of the Association of Thoracic Surgeons early in 1944 a proposal that it should be enlarged to include physicians to meet this need was considered but not accepted. Another suggestion was that a section for chest diseases might be formed within the Royal Society of Medicine and on 14 March 1944 a meeting of some of those in London who might be interested was convened by Tudor Edwards at his house in Harley Street to consider this informally. Tudor Edwards took the chair, and the others present were the physicians Clifford Hoyle, James Livingstone, Geoffrey Marshall, James Maxwell, and Lloyd Rusby; the surgeons Russell Brock, Holmes Sellors, Price Thomas, and OS Tubbs; and the radiologist LG Blair. After discussion it was unanimously agreed that the formation of a "society for the study and development of knowledge in Diseases of the Chest," independent of the Royal Society of Medicine, was desirable. A working committee with Clifford Hoyle as secretary was formed.

A further meeting on 31 March 1944 was attended by Tudor Edwards (as chairman), Clifford Hoyle, LE Houghton, JL Livingstone, J Maxwell, RC Brock, JEH Roberts, T Holmes Sellors, OS Tubbs, SR Gloyne, M Nosworthy (anaesthetist), and LG Blair. The terms of a letter to be sent to those being invited to become founder members were agreed. This referred to the objects of the new society, including the publication of a journal, and emphasised that it was not intended to compete with the Tuberculosis Association. The membership would include "radiologists, anaesthetists, pathologists, laryngologists and others concerned with the subject" as well as physicians and surgeons. It would be a requirement that clinicians should hold an appointment on the consulting staff of a general hospital or special chest hospital. Unfortunately, no copy of the list of those who were to receive this letter appears to have survived, but at a later meeting of the working party it was reported that 136 letters had been sent. Only seven of those approached had declined the invitation, five on grounds of seniority; and, of 24 from whom there had been no reply, most were known to be on active service overseas. The first general meeting was planned for July 1944 but had to be postponed because of war conditions; it was eventually held at Manson House on 26 January 1945. In the meantime further meetings of the working party had discussed the constitution and name of the society and the proposed journal. At the first general meeting 53 people were present, including 15 "from the Provinces." The draft rules were adopted; they

provided for the limitation of membership to 150 full and 50 associate members, at annual subscriptions of 2 guineas and 30 shillings respectively, which covered the journal. Officers and council were elected, Tudor Edwards being the first president. Of several suggested names for the new society, the Association for the Study of Diseases of the Chest was preferred, though both "Thoracic Society" and "British Thoracic Society" were also considered. Norman Barrett and Clifford Hoyle were elected editors of the proposed journal, but the name of this was not discussed.

At two meetings of the executive council in April 1945 the chief subjects considered were the journal and the first scientific meeting. No existing British journal covered exactly the interests of the new association. *Tubercle* was almost exclusively concerned with tuberculosis. The *British Journal of Tuberculosis* had extended its interests to include other lung diseases and had recently added *and Diseases of the Chest* to its name, but had not been much concerned with laboratory studies or surgery. This journal was owned by its publisher and was also edited by Clifford Hoyle. An obviously convenient arrangement was for the association to adopt this journal, which would mean acquiring from the publisher effective editorial control. At the same time the possibility of publication by the British Medical Association was considered; the editorial department of the BMA published journals for several specialist societies and offered the advantages of the backing of an established organisation in the technical problems and financial uncertainties of medical publishing. After much discussion it was decided to recommend that the journal should be published by the BMA, that its name should be *Thorax*, and that an attempt should be made to negotiate the transfer of the *British Journal of Tuberculosis and Diseases of the Chest* to the BMA, so that the new journal could replace it. (The name *Chest*, later adopted by the American College of Chest Physicians for its journal, was considered but rejected as being "less international" than *Thorax*.) At the general meeting which preceded the first scientific meeting of the Association for the Study of Diseases of the Chest on 27 July 1945 these recommendations were accepted. The scientific programme consisted of the presidential address on bronchial carcinoma, later published in the first number of *Thorax*, and a discussion on pneumonitis.

The executive council continued discussions over the publication of *Thorax*. The publishers of the *British Journal of Tuberculosis and Diseases of the Chest* were unwilling to dispose of their rights in that journal and considered that there was a place for two journals dealing with diseases of the chest, as well as one concerned specifically with tuberculosis. Clifford Hoyle felt a personal commitment to the

journal and therefore resigned the editorship of *Thorax*. His resignation was regretfully accepted and JG Scadding was nominated and later elected to join NR Barrett as editor. The first number of *Thorax* was published in March 1946. Publication by the BMA proved advantageous from the beginning, and has contributed greatly to the success of the journal.

At the general meeting in January 1946 at Manson House, London, 94 members were present. Ronald Edwards suggested that a committee should be appointed to consider nomenclature of the bronchial tree and lung segments; this was later agreed and implemented, and the recommendations of the committee were published in *Thorax* in 1950. The scientific business consisted of discussions on lung abscess and on pulmonary oedema and a pathology demonstration. An informal dinner at Claridges cost 25 shillings. The summer 1946 meeting, held in Liverpool, included discussions on bronchitis, anoxia, and indications for operation in bronchiectasis.

The first president, Tudor Edwards, died in August 1946 and Roodhouse Gloyne, one of the vice-presidents, took over the presidency for two executive committee meetings in October 1946 and January 1947. Two items discussed are of historic interest. A senior physician, distinguished for his work on tuberculosis, was nominated for membership as a special case, with the note that "physicians engaged in tuberculosis work only should not be admitted. This was not related to their contributions to medicine, but to the difficulty of drawing a line to prevent the Association becoming indistinguishable from the Tuberculosis Association." Secondly, it deferred consideration of a letter from the American College of Chest Physicians suggesting that the association should seek affiliation with that body.

In 1947 meetings were held in London in the winter and in Newcastle upon Tyne in the summer under the presidency of Geoffrey Marshall. At the winter meeting short communications appeared for the first time in the scientific programme; Norman Barrett opened a discussion on tumours of the chest wall and a discussion on respiratory function tests was opened by a surgeon, Clarence Crafoord. The Newcastle upon Tyne meeting was timed to precede that of the Tuberculosis Association in Edinburgh, so that those who were members of both could proceed from one to the other. Subjects discussed included the surgery of cardiac ischaemia and dust diseases of the lung other than silicosis. The suggestion by John Hunter that the name Thoracic Society should be considered was accepted by the executive council the following winter and recommended for approval. Horace Joules suggested that cardiologists should be eligible for membership and this was agreed, as was the sug-

gestion of a joint meeting with the Cardiac Society.

Meetings in 1948 were held in London and Birmingham. The London meeting was attended by 124 members and 52 guests; there were discussions on the pathology of bronchiectasis, anaesthesia for Blalock's operation, and spontaneous pneumothorax. At the Birmingham meeting, in addition to short papers there was a discussion of peptic ulcer of the oesophagus. Morrision Davies gave a "Provocative Talk on Pulmonary Tuberculosis," which lasted two hours; and the name Thoracic Society was finally approved.

Thus by 1948 the name and constitution of the society were decided. It was to be a private society of limited membership, composed of medical practitioners and others concerned with any aspect of thoracic disease and especially with teaching and research, but excluding those engaged primarily in tuberculosis work, selected by nomination and election after consideration by the executive committee. Its activities consisted of scientific meetings and the publication of a journal. The pattern of its meetings was established: a winter or spring meeting in London and a summer meeting at another university centre, with programmes consisting of symposia on selected topics and short papers on recent scientific work. Short papers formed an increasing proportion of the scientific programme and precirculation of abstracts became the rule. Occasional joint meetings, usually for part of a two-day programme, were arranged with societies having related interests. The first of these was with the Cardiac Society in London in February 1949, when the subject discussed was the surgery of congenital heart disease. Later in the same year the first overseas meeting was held in Oslo jointly with the corresponding Norwegian society. It has been followed by joint meetings, both abroad and in Great Britain, with other national societies—Danish, Swedish, French, American and Belgian. A list of presidents, together with the places of the summer meetings, is given at the end of this article.

The society has received from members several gifts of historic interest. Robert Coope, president in 1951, presented a monaural stethoscope, the history of which he has recounted.² It is a handsome instrument decorated with ivory and bears a silver band with the inscription: "Prize for Auscultation presented by Dr Hope to GL Bampton, 1836–7." It was displayed on the chairman's table at scientific meetings and adopted as the emblem of the society. Robert Pierret, a French honorary member, presented a first edition of the two volumes of Laennec's *De l'Auscultation Médiante* (1819). Richard Trail presented a gavel made from the wood of a walnut tree said to have been growing in the garden of Caius College, Cambridge, in William Harvey's time. Another gave

was presented by the Australian Thoracic Society at the Cardiff meeting in 1972, when colleagues from the Commonwealth were specially invited, under the presidency of HM Foreman—himself a New Zealander.

The concept of the society as a private body concerned only to be a forum for discussion among its members was carefully maintained. Suggestions that public pronouncements might be made on such topics as chronic bronchitis and smoking or the organisation of chest clinics were resisted, on the grounds that they would infringe the rule that no report of the society's proceedings could be made except in its private minutes or its journal. As late as 1971 the nomination of members of the Royal College of Physicians Committee on Thoracic Medicine was left to the British Thoracic and Tuberculosis Association.

Changes in disease prevalence and consequently in the organisation of medical services soon caused difficulties in the implementation of the rule limiting membership and in maintaining the balance between specialties within it. In 1945 the old tuberculosis service was already being changed into a system of chest clinics. With the coming of the National Health Service in 1948 this change was recognised by the transfer of responsibility for these clinics from local authorities to regional hospital boards and their gradual incorporation into general hospitals. This led to a large increase in the number of physicians eligible for membership of the Thoracic Society, from which their predecessors had been excluded by the policy that in general those concerned only with tuberculosis were not favourably considered. Respiratory physiology was expanding both as a clinical subspecialty and as a laboratory discipline and the immunology of respiratory disease was attracting the attention of increasing numbers of physicians. Thus the number of physicians concerned with various aspects of respiratory disease was becoming much greater than had been envisaged when the society was founded, while the numbers of radiologists, pathologists, and anaesthetists making contributions to the study of bronchopulmonary disease were certainly not diminishing.

The changing interests of surgical members presented other problems. In 1945 the surgery of the heart was limited to a few "closed" procedures and constituted a minor part of the activities of a few thoracic surgeons. The development of new techniques, especially those made possible by cardiopulmonary bypass, led to a rapid increase in the proportion of the time most thoracic surgeons devoted to cardiac surgery and later to a tendency for surgeons to concentrate on either cardiac surgery or the surgery of the lungs and other intrathoracic structures. Moreover, the number of patients who required the collaborative attention of thoracic

surgeons and physicians was diminishing, despite the increasing incidence of lung cancer. From the middle 1950s onwards the success of antibacterial chemotherapy led to the virtual end of the surgery of pulmonary tuberculosis and the need for surgery in the treatment of pulmonary and pleural suppurative diseases also diminished strikingly. To cater for the full range of interests of surgical members papers on surgical cardiological topics were included in scientific programmes and this consideration influenced the decision that cardiologists should be eligible within the limited membership.

These diverse factors have led to recurrent difficulties and some arbitrariness in decisions about the admission of new members. Despite repeated amendments of the rules relating to the number of members, arguably not all those eligible and likely to contribute have been admitted to the society. On the other hand, the limitation of membership spread over clinical and laboratory disciplines has given the society a special character which carries over from its beginnings in the thoracic surgical centres, when these tended to be the focal points of clinical skills in pulmonary and other intrathoracic disease.

Many, but not all, of the founder members of the Thoracic Society were members of the Tuberculosis Association, which had always been an "open" society without numerical limitation of membership and taking an active part in public relations with governmental and other bodies concerned with the control of tuberculosis. At that time there was a clear distinction between the two societies in purposes and activities, as well as in constitution, though clinically their scientific interests overlapped. With the changes in clinical organisation in respiratory medicine the extent of this overlap steadily increased and the widening concern of the Tuberculosis Association with all aspects of bronchopulmonary disease was marked by changes in its name by stages to the British Thoracic Association.¹ Three physicians have been president of both societies: JG Scadding (British Tuberculosis Association 1959–61; Thoracic Society 1971); NC Oswald (British Tuberculosis Association 1965–7; Thoracic Society 1974); and JW Crofton (British Thoracic and Tuberculosis Association 1973–5; Thoracic Society 1977). The first joint meeting of the two societies was held at Lancaster in 1970; others were held in Nottingham in 1973 and in London in 1980, 1981, and 1982. The community of scientific interests which had developed between the two societies was thus acknowledged. Difficulties, practical and sentimental, inevitably stood in the way of amalgamation of two societies of such differing constitution. They have been resolved by the devoted work of the last two presidents and their officers and councils, leading to the dissolution of both societies

and the birth of a single new one at a final joint meeting at York University in July 1982. The histories of the Thoracic Society and of the society which began as the Tuberculosis Association and became the British Thoracic Association are complete. The history of the British Thoracic Society, designed to continue the best traditions of both, has begun.

References

- ¹ British Thoracic Association. *The British Thoracic Association: the first fifty years*. London: BTA, 1978.
- ² Coope R. Mr Bampton's prize: or the tale of an old stethoscope. *Lancet* 1952;ii:577-80.

Presidents and summer meetings of Thoracic Society.

	<i>President</i>	<i>President's speciality</i>	<i>Place of meeting</i>
1944-6	A Tudor Edwards	Surgeon	Liverpool (1946)
1946	A Roodhouse Gloyne	Pathologist	
1947-8	Geoffrey Marshall	Physician	Newcastle upon Tyne (1947)
1948-9	C Price Thomas	Surgeon	Birmingham (1948)
1950	VE Negus	Laryngologist	Oslo (1949)
1951	Robert Coope	Physician	Bristol
1952	RC Brock	Surgeon	Dublin
1953	FH Young	Physician	Cardiff
1954	A Graham Bryce	Surgeon	Oxford
1955	I de Burgh Daly	Physiologist	Manchester
1956	JL Livingstone	Physician	Cambridge
1957	GA Mason	Surgeon	Aberdeen
1958	Philip Allison	Surgeon	Newcastle upon Tyne
1959	J Clifford Hoyle	Physician	Copenhagen
1960	T Holmes Sellors	Surgeon	Oxford
1961	AS Johnstone	Radiologist	Edinburgh
1962	AG Ogilvie	Physician	Harrogate
1963	NR Barrett	Surgeon	Paris
1964	AB Taylor	Physician	Cambridge
1965	KR Robson	Physician	Birmingham
1966	KFW Hinson	Pathologist	Sheffield
1967	G Simon	Radiologist	Sussex
1968	AL d'Abreu	Surgeon	Dublin
1969	CM Fletcher	Physician	Glasgow
1970	A Logan	Surgeon	Keele
1971	JG Scadding	Physician	Lancaster
1972	HM Foreman	Physician	East Anglia
1973	OS Tubbs	Surgeon	Cardiff
1974	NC Oswald	Physician	Nottingham
1975	WM Macleod	Physician	Cambridge
1976	FR Edwards	Surgeon	Exeter
1977	JW Crofton	Physician	Liverpool
1978	R Abbey Smith	Surgeon	San Francisco, Edinburgh
1979	P Hugh-Jones	Physician	Bruges, Oxford
1980	Michael Bates	Surgeon	Paris
1981	IWB Grant	Physician	Durham
1982	BB Milstein	Surgeon	St Andrews
			York